Melina Sattari, MA, LMFT
22231 Mulholland Hwy, Suite 112, Calabasas, CA 91302
818-448-2735

INFORMED CONSENT

Date _____

Full Name_____ Age_____ Date of birth_____

Address _____

City _____ Zip _____ Phone _____

Marital Status _____ Gender: Male_____ Female_____

Emergency Contact Name _____ Relationship _____

Phone_____

This Informed Consent form is intended to provide sufficient information for you to make informed choices about entering and continuing therapeutic treatment. The specifics of treatment goals and the steps to achieve these goals will be discussed at the first appointment. Your participation and understanding of the treatment goals is essential for the best benefit of therapy.

PSYCHOTHERAPY SERVICES

Psychotherapy varies deepening on the personalities of psychotherapist and client, and the particular problems you bring forward. These are many different methods I may use to deal with the problems you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it is a collaborative work between the therapist and client. In order for the therapy to be most successful, you will have to work on the things we talk about during our sessions and at home.

PROFESSIONAL FEES

The fee for individual, couple, or family therapy session is $_____per 50 minute session. Payment is accepted in the form of cash, check, or Venmo. Fees are re-evaluated and subject to change every six months.

PAYMENT POLICY

Payment in full is expected at the time of service, unless alternative arrangements are mutually agreed upon. All charges for returned checks are client's responsibility and it is the policy of this office to charge for any bank fees as well as a $35.00 processing fee for a returned check. Any returned check may result in a patient being asked to pay cash for future sessions.

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CANCELATION/NO SHOW

Cancelations must be made 24 hours in advance otherwise client is responsible for the full session fee. A scheduled appointment means that time is reserved only for you.

If you do not show up for your session without notifying me in advance, or if you call to cancel your session within a few hours prior to your session (for example, if you call us to cancel after 12pm for your 3pm appointment), this will be considered a 'No Show,' for which you will be responsible for the full session fee. Please note that, even if you have health insurance covering services at my Center, most insurance companies do not cover late cancellation/no show fees, and so you will be responsible for these fees even if you have insurance.

Reasonable exceptions will be made to these Late Cancellation & No Show fees, depending on one's circumstances.

☐ **Please check this box indicating that you are aware of, understand, and agree to the Cancellation and No Show Policy above.**

CONFIDENTIALITY

The information you share with me will be kept strictly confidential and will not be discussed without your written consent. Only upon request and/or your permission may any part of files be released to any person or agency you designated. You should know that there are certain situations in which as a therapist, I am required **by law** to reveal information obtained during therapy to other persons or agencies. These situations are as follows:

1. If you reveal and/or I have sufficient reason to suspect that a child or elder has been neglected, abused, or sexually molested, I must report this information to the appropriate protective services agency.
2. If you are in therapy by order of a court of law, the results of the treatment ordered may be revealed to the court or acting agency.
3. California courts have held that if an individual intends to take harmful or dangerous action against another person or property, I am required by law to inform the intended victim(s) and appropriate law enforcement agencies.
4. If a court of law issues a legitimate subpoena, I am required to provide the information requested by the court.

NOTE: In any situation in which a client expresses, or the therapist has reasons to suspect suicide ideations, the therapist has an ethical responsibility to intervene for the safety of the

client. This could include informing family, significant others, police or psychiatric evaluation team.

CLIENT CONSENT TO PSYCHOTHERAPY

I have read this consent form, I had sufficient time to be sure that I considered it carefully, I asked any questions that I needed to, and I understand it. If I have any remaining questions, I may ask them now. I understand the issues of confidentiality, my rights and responsibilities as a client, and my therapist's responsibilities to me. I understand everything above, and I agree to receive services at the Center.

Your signature constitutes an agreement to enter into treatment with Melina Sattari for therapy and signals that you have read, understand and agree to the information provided within this agreement.

I have read the consent form, and I have had sufficient time to be sure that I considered it carefully. I have asked any questions that I needed to ask, and if I have any remaining questions I may ask them now.

Signature _____ Date _____